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State of New Jersey

DEPARTMENT OF HEALTH
JOHN FITCH PLAZA
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J. RICHARD GOLDSTEIN, M.D
COMMISSIONER

TO: Interested Parties

FROM: Christine Grant, Director Designate
Hospital Reimbursement, Health
Planning and Resources Development

SUBJECT: Rebundling of Non-Physician Services

DATE: July 12, 1984

The accompanying policy papers outline two overlapping but distinct aspects of the rebundling of non-physician services:

The first describes the types of services which hospitals may identify as rebundable; and

The second outlines the protocol proposed to be used by the Department staff and Hospital Rate Setting Commission to determine approval or disapproval of rebundled services as submitted by the hospital, and the appropriate charges that may be made for each.

The protocol will be brought before the Hospital Rate Setting Commission for approval on August 1, 1984.

At that time, any party who wishes to comment on the protocol, may do so. Please try to submit comments to the Department before the Hospital Rate Setting Commission meets. In this way, changes can be made prior to the meeting.

Comments may be submitted, in writing, to me at the following address:

New Jersey Department of Health
Hospital Reimbursement
CN 360, Room 601
Trenton, NJ 08625

If you have any questions, contact Steven Bilsky at (609) 292-0088.

CG:svf
Attachments

c. Joseph I. Morris
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Prepared by Steven D. Bilsky
July 12, 1984

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On January 12, 1984, the Health Care Administration Board (HCAB) approved an emergency regulation requiring "rebundling" of non-physician services. The intent of this regulation was to ensure that Medicare Part A Fund would be responsible for all inpatient costs as required by the Tax Equity and Fiscal Responsibility Act of 1982. Conversely, Medicare Part B Fund would then be responsible for only physician costs and outpatient costs. In order to accomplish this, it was necessary to have all non-physician services and supplies, that are necessary for the treatment of inpatients (provided by an external source) be billed through the admitting hospital and listed separately on the inpatient bill as miscellaneous charges. It is envisioned that these charges will eventually be included in the hospital's DRG price per case. Of course, in New Jersey this provision had to be mandated for all payers.

Since publication of this regulation, a number of questions have been raised concerning the rebundling of non-physician services. It is, therefore, necessary for the Department to offer an interpretation of this regulation, developing parameters within which reimbursement will be allowed.

Specifically, there are four areas dealing with the rebundling of non-physician services which require clarification:

1. Unbundling of services which are in the 1982 base;

2. Rebundling of new technology and new procedures;

3. Certificate of Need approval for external vendors providing services with major moveable equipment; and

4. Prior approval.

Unbundling Services in the 1982 Base

Since the 1984 DRG rates are based upon the 1982 hospital actual cost, costs for services provided by the hospital in the base year are naturally in the DRG rate per case. Therefore, if a service was included in the 1982 base, but is now provided by an outside vendor, the hospital is responsible for payment of these services from the reimbursement provided through the DRG rates. However, if the hospital had unbundled these services during 1983, had notified the Department, and had the associated costs removed from the rates, the hospital may request inclusion of these costs as rebundled items. Proof of this activity must be provided to the Department.

As of January 1, 1984, the Department will no longer allow the unbundling and subsequent rebundling of inpatient services. If the hospital chooses to unbundle a particular service, the hospital must expect to receive reimbursement for this service through their prospective DRG payment rates. These services will not be allowed to be billed as a trailer (miscellaneous) charge.

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Rebundling New Technology and New Procedures

The Department defines "new" as any service performed by an external vendor or by the hospital itself, which had not been previously performed in the 1982 base year.

An example of a "new" service would be a hospital's initial referral of inpatients to a private radiology group, to perform a new kind of diagnostic test (NMR), which was not available during 1982 (the base year). The purpose of this policy is to be consistent with the long-standing policy of requiring hospitals to appeal the cost of new technology as in the case of CAT Scanners.

This service cannot be billed as a [illegible] charge, but it is an itemized charge like any other. The hospital would have to pay for this procedure out of the DRG rate per case. The reason for this is that it has always been the Department's policy (consistent with the regulations) that new technology and procedures can be reimbursed (for inliers) only if a technology appeal or a clinical rate appeal is approved by the Hospital Rate Setting Commission. Otherwise, it is assumed that there are cost savings that offset the new costs.

Certificate of Need

In order for a vendor to perform an allowable rebundled service for hospital inpatients, using major moveable equipment, it will be necessary for the vendor to have an approved Certificate of Need (C/N) for this service. In general, these services include the use of major moveable equipment with a value over $150,000. This requirement is made explicit in the emergency regulation approved on January 12, 1984, and is consistent with other State and Federal regulations.

Hospitals will be required to document that the vendors of the rebundled services have an approved C/N.

Prior Approval

Certain payers require "prior approval" from vendors for the provision of specific services or supplies. It should be noted that the rebundling regulation does not preclude a payer from requiring "prior approval". The admitting hospital should guarantee that any outside vendor performing a service for an inpatient has "prior approval" to do so. In most cases, this refers to prosthetic devices being supplied to Medicaid patients.

If prior approval is required by the payer and not obtained, the payer may determine that the service or supply is not a covered benefit.

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PROPOSED PROTOCOL FOR THE EVALUATION OF REBUNDLED CHARGES

Prepared by Steven D. Bilsky
July 12, 1984

The following outlines the protocol proposed for use by the hospital rate analyst and the Hospital Rate Setting Commission (HRSC) in the determination of allowable and reasonable charges for non-physician rebundled services and supplies.

In order to implement the rebundling regulation, the Department is requiring hospitals to supply the following information as a supplemental report to their 1984 Rate Appeal document. These items may be appealed under the accept option. If this information is not supplied to the Department, reimbursement for the rebundled services will not be allowed at Final Reconciliation. (Cost will refer to the amount billed from the outside vendor to the hospital, charge will refer to this cost "bumped-up" by the hospital-specific mark-up factor).

The information is as follows:

1. A list of all non-physician services and supplies (with the appropriate revenue codes) to be rebundled by cost center;

2. The costs, in 1984 rate year dollars, of each rebundled service or supply to the hospital (i.e., no hospital mark-up factor applied);

3. Total number of actual procedures for the rebundled services for January through July and the expected number for August through December. This will be reconciled to actual at Final Reconciliation;

4. Development of the total cost for the rebundled services by cost center;

5. The names of the external vendors performing these services and, where applicable, proof of the existence of a Certificate of Need (C/N Number); and

6. Certification from the hospital financial officer that the appealed items are not in the (1982) rate base.

EXAMPLE:

COST CTR.	REV CODE	RE-BUNDLED SERVICE	EXTERNAL VENDOR PERFORMING THE SERVICE	APPROVED C/N IF YES, SHOW C/N NO.)	CHARGE	PROJECTED FREQUENCY	TOTAL COST
RAD	1.7883	CAT Scan	Hospital	Yes	250	10	2,500
	2.7519	Digital	Radiology	Yes	400	5	2,000
		Angiogram	Group W				4,500